

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03058

03045

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ocean City				c. LENGTH OF STAY IN 1b 8 Yrs.			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Pine St.,				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ocean City			
				d. STREET ADDRESS Pine St.,			
3. NAME OF DECEASED (Type or print) JAMES MARION BEDSWORTH				4. DATE OF DEATH Month 2 Day 28 Year 19 66			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 5, 1899		9. AGE (In years last birth day) 66 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Rentals		10b. KIND OF BUSINESS OR INDUSTRY Real Estate		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wade Bedsworth				14. MOTHER'S MAIDEN NAME Ida Davis			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W. 11 214-10-7919		17. INFORMANT Mrs. J.M. Bedsworth, Same		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocarditis 260X DUE TO Diabetes Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Hypertension (c) Hypertension							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2-28-66 to 2-28-66 , that (I) (we) last saw the deceased alive on never 19....., and that death occurred at 4:15 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Clifford E. Schott				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3-1-1966	
22c. PHYSICIAN'S NAME (Type) Dr. Clifford E. Schott				22d. ADDRESS 314 N. Main St., Berlin, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-3-1966		23c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		23d. LOCATION (City, town or county) (State) Salisbury, Maryland	
24 FUNERAL DIRECTOR'S SIGNATURE Hill Funeral Home				ADDRESS Salisbury, Maryland		25a. REC'D BY REGISTRAR Charles Judge	
				DATE MAR 3 1966		25b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
03059					03046				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)				
a. COUNTY		Worcester			a. STATE		Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Rural-Snow Hill			b. COUNTY		Worcester		
c. LENGTH OF STAY IN 1b		50 years			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Rural-Snow Hill 23-1		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS				
R.F.D. 1					R.F.D. 1				
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH				
First Middle Last					Month Day Year				
GEORGE THOMAS BONNEVILLE					February 12 1966				
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS.	
Male		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		June 16, 1890		75 yrs. Months Days Mln.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Farmer				Farming		Accomack County, Virginia		U.S.A.	
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
William Bonneville					Mary Simpson				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
No		215-38-2218		George T. Bonneville, Jr.		Snow Hill, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]									INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)									2 yrs
163x									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last,									(b)
									(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year				20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
Hour a.m. p.m. 19				While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					
21. I certify that (I) (this hospital) attended the deceased from Jan 1963 to Jan 20 1966 that (I) (we) last saw the deceased alive on Jan 19 1966 and that death occurred at M, from the causes and on the date stated above.									
22a. SIGNATURE					22b. DATE SIGNED				
DAVID RAFAI					SNOW HILL MD.				
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)			
Burial		2-14-1966		Parksley Cemetery		Parksley, Virginia			
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR				
Robert H. Watson					DATE FEB 17 1966				
ADDRESS					25b. REGISTRAR'S SIGNATURE				
Pocomoke City, Md.					J. Charles Judge				

MEDICAL CERTIFICATION

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
350D 4-64

Item 18&21 Film G374 3/14/66 TM													
MARYLAND STATE DEPARTMENT OF HEALTH													
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
MEDICAL EXAMINER'S CERTIFICATE OF DEATH													
Item 9 Film G374 3/11/66 nm													
1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>WOR.</u>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Bishop</u>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Bishop</u>							
c. LENGTH OF STAY IN 1b <u>31 years</u>						d. STREET ADDRESS <u>R-1 Bishop, Md.</u>							
3. NAME OF DECEASED (Type or print) <u>Blanche Ellen Davis</u>						4. DATE OF DEATH <u>Feb 27, 1966</u>							
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 13, 1906</u>		9. AGE (In years last birthday) <u>59 yrs.</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>clerk</u>						11b. KIND OF BUSINESS OR INDUSTRY <u>Retail Store</u>		11. BIRTHPLACE (State or foreign country) <u>Delmar, Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>William E. Workman</u>						14. MOTHER'S MAIDEN NAME <u>Carnie (Unknown)</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>						16. SOCIAL SECURITY NO. <u>221-18-6383</u>		17. INFORMANT <u>HERMAN DAVIS, husband, Bishop, Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HEMIPLEGIA/STROKE/ATROPHY</u> <u>4221</u> DUE TO <u>Pulmonary edema</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ASCVD</u> DUE TO (c) <u>ASCVD</u>												INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u> <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Epilepsy</u>												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <u>F.J. Townsend, Jr.</u>						M.O. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
EXAMINER'S NAME (Type) <u>F.J. Townsend, Jr.</u>						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Oscar City, Md.</u>							
22. DATE SIGNED <u>Feb. 27, 66</u>													
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>3/1/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Iron Church yard</u>		23d. LOCATION (City, town or county) (State) <u>Bishopville, Md.</u>					
24. FUNERAL DIRECTOR <u>Titus Whaley</u>						ADDRESS <u>Salisbury, Md.</u>		25a. REC'D BY REGISTRAR <u>MAR 3 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "REPORT" and "DATE" are faintly visible.]

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VR A15 (4)
20M 1/65

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
03061 CERTIFICATE OF DEATH 03048											
1. PLACE OF DEATH a. COUNTY Worcester MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City					c. LENGTH OF STAY IN 1b 5 years						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 1013 Clarke Avenue					d. STREET ADDRESS 1013 Clarke Avenue						
3. NAME OF DECEASED (Type or print) PENCIA RIGGIN GODWIN					4. DATE OF DEATH Month February Day 21 Year 19 66						
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 31, 1888		9. AGE (In years last birthday) 78 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife					10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (County & State, or foreign country) Accomack County, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Ackbud Riggins					14. MOTHER'S MAIDEN NAME Betty Bevans						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. --		17. INFORMANT Mrs Annie Marshall, Pocomoke City, Md.		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular Asystole 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Heart Block DUE TO (c) Arteriosclerotic Heart Disease									INTERVAL BETWEEN ONSET AND DEATH Minutes Years Years		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. _____ p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to 2/21/66 , 19____, that (I) (we) last saw the deceased alive on 2/21/66 , and that death occurred at 645a , from the causes and on the date stated above.											
22a. SIGNATURE <i>Charles W. Trader</i>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Feb. 22, 1966.			
22c. PHYSICIAN'S NAME (Type) Charles W. Trader, M.D.						22d. ADDRESS Pocomoke City, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 2-23-1966		23c. NAME OF CEMETERY Downing Cemetery			23d. LOCATION (City, town or county) (State) Oak Hall, Virginia			
24. FUNERAL DIRECTOR <i>Robert H. Watson</i>						ADDRESS Pocomoke City, Md.		25a. REC'D BY REGISTRAR FEB 25 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Worcester b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural Berlin c. LENGTH OF STAY IN 1b 2 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) R. F. D.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Berlin Rural d. STREET ADDRESS R. F. D. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Frederick Vaughn Lyons		4. DATE OF DEATH Month Feb. Day 17 Year 1966	
5. SEX Male	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 8, 1902
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR Months 1 Days 17 Hours 00 Min. 00	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chef		10b. KIND OF BUSINESS OR INDUSTRY Restaurant	
11. BIRTHPLACE (State or foreign country) Trappe Md		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Fritz Lyons		14. MOTHER'S MAIDEN NAME Julia Merrick	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 162-18-1715	
17. INFORMANT Mrs. Betty Dayton		Address Berlin, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subarachnoid Hemorrhage at base of brain 330X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Clifford E. Schott		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Clifford E. Schott, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Acting		22. DATE SIGNED 2-19-66	
Address (Street, city, town, or county) Berlin Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2-20-66	23c. NAME OF CEMETERY OR CREMATORY Windy Hill Cemetery	23d. LOCATION (City, town or county) (State) Trappe Md.
24. FUNERAL DIRECTOR Anne A. Burbage		25a. REC'D BY REGISTRAR FEB 23 1966	
ADDRESS Berlin Md		25b. REGISTRAR'S SIGNATURE J Charles Judge	

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
03063 CERTIFICATE OF DEATH 03050										
1. PLACE OF DEATH a. COUNTY Worcester MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Pocomoke City					c. LENGTH OF STAY IN lb minutes					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 408 Oxford Street					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural - Pocomoke City 23-1					
					d. STREET ADDRESS R.F.D. 2					
3. NAME OF DECEASED (Type or print) JAMES GROVER MADDOX					4. DATE OF DEATH Month February Day 22 Year 1966					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 20, 1886		9. AGE (In years last birthday) 79 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (County & State, or foreign country) Worcester County, Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Sylvester Maddox					14. MOTHER'S MAIDEN NAME unknown					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. --		17. INFORMANT Miss Helen Maddox, Pocomoke City, Md.						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Arteriosclerotic Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>										
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from 1/23/54 , 19__, to 2/22/66 19__, that (I) (we) last saw the deceased alive on 2/8/66 19__, and that death occurred at 145M , from the causes and on the date stated above.										
22a. SIGNATURE Charles W. Trader					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 2/23/66			
22c. PHYSICIAN'S NAME (Type) Charles W. Trader, M.D.					22d. ADDRESS 302 Market St., Pocomoke City, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-25-1966		23c. NAME OF CEMETERY First Baptist		23d. LOCATION (City, town or county) (State) Pocomoke City, Maryland				
24. FUNERAL DIRECTOR Robert H. Watson					ADDRESS Pocomoke City, Md.		25a. REC'D BY REGISTRAR 1 MAR 1 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

1225

Postmaster
Post Office
1000 Main Street
New York, N.Y.

James
Graham
Knox
to
New York, N.Y.

Postmaster
Post Office
1000 Main Street
New York, N.Y.

Postmaster
Post Office
1000 Main Street
New York, N.Y.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03064

03051

1. PLACE OF DEATH a. COUNTY Worcester		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Berlin		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bishopville	
c. LENGTH OF STAY IN 1b Lifetime		d. STREET ADDRESS none	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Berlin Nursing Home			
3. NAME OF DECEASED (Type or print) Eva K. Mumford		4. DATE OF DEATH Month Feb. Day 14 Year 19 66	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/19/1882
9. AGE (in years last birthday) 83 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 2 Days 3 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Worcester county, Md.	
11. BIRTHPLACE (County & State, or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Handy		14. MOTHER'S MAIDEN NAME Nancy Hearne	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. Isaiah Mumford	
17. INFORMANT Selbyville, Dela.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic myocarditis 443x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c) Arteriosclerosis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral hemorrhage - apoplexy 6 mths ago			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1958 , 19, to 2-14 , 19 66 , that (I) (we) last saw the deceased alive on 2-14 , 19 66 , and that death occurred at 29 M, from the causes and on the date stated above.			
22a. SIGNATURE Frank R. Lewis		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Dr. Frank R. Lewis		22d. ADDRESS Willards, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/17/66	
23c. NAME OF CEMETERY OR CREMATORY Odd Fellows Cem.		23d. LOCATION (City, town or county) (State) Bishopville, Md.	
24. FUNERAL DIRECTOR Henry H. Watson		25a. REC'D BY REGISTRAR Pocomoke City, Md.	
25b. REGISTRAR'S SIGNATURE FEB 16 1966		25c. REGISTRAR'S SIGNATURE Charles Judge	

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[Faint, mostly illegible text covering the page, possibly bleed-through from the reverse side. Some words like "THE", "AND", "OF" are visible.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
03065 04567									
1. PLACE OF DEATH a. COUNTY <i>Worcester Co</i> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Curles</i> c. LENGTH OF STAY IN <i>md</i> <i>MD</i> <i>yes</i> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Worcester</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Curles</i> d. STREET ADDRESS <i>23-1</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <i>Addie</i> Middle <i>Postlay</i> Last <i>Postlay</i>					4. DATE OF DEATH Month <i>Feb</i> Day <i>24</i> Year <i>1966</i>				
5. SEX <i>F</i>		6. COLOR OR RACE <i>C</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>3-15-82</i>		9. AGE (In years last birthday) <i>83</i> yrs. IF UNDER 1 YEAR Months <i>-</i> Days <i>-</i> IF UNDER 24 HRS. Hours <i>-</i> Min. <i>-</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Worcester Co</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Bes Padden</i>					14. MOTHER'S MAIDEN NAME <i>Jane Henry</i>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				16. SOCIAL SECURITY NO. <i>217-12-444</i>		17. INFORMANT <i>Addie Andrews</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis -</i> <i>332X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Generalized arteriosclerosis</i> DUE TO (c) <i>10 yrs.</i>								INTERVAL BETWEEN ONSET AND DEATH <i>one wk</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <i>Sept 1962</i> to <i>2/24/66</i> , that (I) <i>(two)</i> last saw the deceased alive on <i>2/24/66</i> , and that death occurred at <i>7A</i> AM, from the causes and on the date stated above.									
22a. SIGNATURE <i>Frank E. Gantz, Jr.</i> M.D.				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <i>FRANK E. GANTZ, JR. M.D.</i>			
22d. ADDRESS <i>5 BAY ST. BERLIN, MD</i>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Feb 28 1966</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Quinto Corn</i>		23d. LOCATION (City, town or county) (State) <i>Whaleyville md</i>			
24. FUNERAL DIRECTOR'S SIGNATURE <i>Booker Greene</i>				ADDRESS		25a. REC'D BY REGISTRAR <i>MAR 11 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

5284

TO HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it is completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
03066					03052									
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)									
a. COUNTY <i>Worcester</i>					a. STATE <i>Maryland</i>									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Berlin, Md.</i>					b. COUNTY <i>Worcester</i>									
c. LENGTH OF STAY IN 1b <i>All Life</i>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Berlin Maryland 23-1</i>									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS <i>Rt # 3</i>									
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH			5. SEX			6. COLOR OR RACE					
First Middle Last <i>Emerson Purnell</i>			Date Month Day Year <i>2 7 1966</i>			<i>Male</i>			<i>Negro</i>					
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <i>Nov. 20-10</i>			9. AGE (In years last birthday) <i>55 yrs.</i>			IF UNDER 1 YEAR Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <i>Worcester</i>			12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>					
13. FATHER'S NAME <i>William</i>					14. MOTHER'S MAIDEN NAME <i>Addie Dennis</i>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)					16. SOCIAL SECURITY NO. <i>213-05-844</i>					17. INFORMANT <i>Annie Belle Franklin - Berlin Md.</i>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4201</i> <i>Acute myocardial infarction</i> DUE TO (b) <i>Myocardial Insufficiency</i> DUE TO (c) <i>4201</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <i>10 min.</i>					2 mos.				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
Bronchial Asthma														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				
20f. (City or town) (County) (State)														
21. I certify that (I) this hospital attended the deceased from <i>8/10/55</i> , 19 <i>19</i> , to <i>2/5/66</i> , 19 <i>19</i> , that (I) was last saw the deceased alive on <i>2/5/66</i> , 19 <i>19</i> , and that death occurred at <i>5</i> AM, from the causes and on the date stated above.														
22a. SIGNATURE <i>Ivory U. Sully, Jr.</i>					22b. DATE SIGNED <i>2/8/66</i>									
22c. PHYSICIAN'S NAME (Type) <i>Ivory U. Sully, Jr., MD</i>					22d. ADDRESS <i>P. O. Box 126, Berlin, Md.</i>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>					23b. DATE THEREOF <i>2-12-66</i>					23c. NAME OF CEMETERY OR CREMATORY <i>Evergreen</i>				
23d. LOCATION (City, town or county) (State) <i>Berlin, Md.</i>														
24. FUNERAL DIRECTOR <i>Loretta B. Jolley-Jersup</i>					25a. REC'D BY REGISTRAR <i>Salis, Md.</i>					25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 03067 CERTIFICATE OF DEATH 03053									
1. PLACE OF DEATH a. COUNTY <u>WORCESTER</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u> c. LENGTH OF STAY IN b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u> 23-1 d. STREET ADDRESS <u>200 FRANKLIN AVE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last <u>LEVI BRIMER ZUILLEN</u>			4. DATE OF DEATH Month Day Year <u>FEB. 3 1966</u>		5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>SEPT. 6, 1888</u> 9. AGE (In years last birthday) <u>77</u> yrs. IF UNDER 1 YEAR Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED R.R.</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>RAILROAD</u>		11. BIRTHPLACE (County & State, or foreign country) <u>BERLIN, MD R.F.D.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GEORGE W. ZUILLEN</u>			14. MOTHER'S MAIDEN NAME <u>MARGARET LYNCH</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>214-10-9668</u>		17. INFORMANT Address <u>Mrs. L. B. ZUILLEN, BERLIN MD</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>4201</u> DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> OUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> <u>5 yrs</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <u>11/19, 1963</u> to <u>2/2, 1966</u> , that (I) (we) last saw the deceased alive on <u>2/2, 1966</u> , and that death occurred at <u>3:40 PM</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>John Z. Quelly - Jr.</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2/4/66</u>			
22c. PHYSICIAN'S NAME (Type) <u>Ivory U. Sully, Jr. MD</u>				22d. ADDRESS <u>Berlin, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>2/5/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>			23d. LOCATION (City, town or county) (State) <u>BERLIN MD</u>		
24. FUNERAL DIRECTOR <u>Anna R. Burtage</u>				ADDRESS <u>Berlin Md</u>		25a. REC'D BY REGISTRAR <u>Feb 7 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

62080

1972-10-31

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10/31/72

10/31/72

10/31/72

10/31/72

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03068

03054

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural - Pocomoke</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural - Pocomoke City</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Rural - Pocomoke</u>		d. STREET ADDRESS <u>Route 3</u>	
3. NAME OF DECEASED (Type or print) <u>Noah Thomas Staton</u>		4. DATE OF DEATH <u>Feb. 12 1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 6 1871</u>
9. AGE (In years last birthday) <u>94</u> yrs.		10. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	
13. FATHER'S NAME <u>Joseph Staton</u>		14. MOTHER'S MAIDEN NAME <u>Rose Ann ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Joseph Staton</u>		Address <u>Route 3 Pocomoke, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> <u>4330</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>GEN. ART. SCLEROSIS</u> DUE TO (c) <u>25 YRS.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>2/14</u> , 19 <u>66</u> , to <u>2/12</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>2/10</u> , 19 <u>66</u> , and that death occurred at <u>11</u> A.M., from the causes and on the date stated above.			
22a. SIGNATURE <u>Neville A. Baron</u>		22b. DATE SIGNED <u>2/14/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>NEVILLE A. BARON</u>		22d. ADDRESS <u>Pocomoke, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2-19-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Hope Cem.</u>	23d. LOCATION (City, town or county) (State) <u>Stockton, Md.</u>
24. FUNERAL DIRECTOR <u>Samuel Sarge</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>New Church, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>FEB 21 1966</u>			

1971
M.D.

FEB 21 1982

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03069

03055

1. PLACE OF DEATH a. COUNTY Worcester b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Pocomoke City c. LENGTH OF STAY IN 1b 5 months d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Hartley Hall Nursing Home				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Crisfield d. STREET ADDRESS 257 Somerset Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) NORA		First A.		Middle WARD		Last		4. DATE OF DEATH Month February Day 20 Year 19 66	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 5, 1877		9. AGE (in years last birthday) 89 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (County & State, or foreign country) Crisfield, Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME John Evans				14. MOTHER'S MAIDEN NAME Florence Sterling					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service) None				16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Sarah Bradshaw, Marion, Md. RFD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) Cerebral Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Atherosclerotic Heart Disease								INTERVAL BETWEEN ONSET AND DEATH 3 days Years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept. 1, 19 65 , to Feb. 20, 19 66 , that (I) (we) last saw the deceased alive on Feb. 20, 1966 , and that death occurred at 25550M , from the causes and on the date stated above.									
22a. SIGNATURE Charles W. Trader, M.D.				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Feb. 22, 1966			
22c. PHYSICIAN'S NAME (Type) Charles W. Trader, M. D.				22d. ADDRESS Pocomoke City, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 22, 1966		23c. NAME OF CEMETERY OR CREMATORY Crisfield Cemetery		23d. LOCATION (City, town or county) (State) Crisfield, Maryland			
24. FUNERAL DIRECTOR ADDRESS Bradshaw & Sons, Crisfield, Maryland				25a. REC'D BY REGISTRAR FEB 28 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge			

0505

RECEIVED

1963

Handwritten notes and stamps, including "RECEIVED" and "1963".

Handwritten notes and stamps, including "RECEIVED" and "1963".

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 3 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
03070 MEDICAL EXAMINER'S CERTIFICATE OF DEATH					03056				
1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>			c. LENGTH OF STAY IN ID <u>all life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>			23-1	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS <u>111 Martin Street</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Roger</u>			First Middle Last <u>Williams</u>		4. DATE OF DEATH Month <u>2</u> Day <u>15</u> Year <u>1966</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>96</u> 10-25-9/5		9. AGE (In years last birthday) <u>69</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Worcester</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Williams</u>					14. MOTHER'S MAIDEN NAME <u>Ellen Funnell</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT <u>5403 Earltran Drive</u> <u>Nora Williams</u> <u>Thila, Va.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>DROWNING</u> <u>9298</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b) <u>ALCOHOLISM</u>								INTERVAL BETWEEN ONSET AND DEATH <u>?</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>Fell into river</u>						
20c. TIME OF INJURY Month, Day, Year Hour <u>?</u> e.m. <u>2/15/66</u> 19			20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Pocomoke River</u>		20f. (City or town) <u>Snow Hill</u> (County) <u>Wor.</u> (State) <u>Md.</u>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>Robert C. La Mar</u>			M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				22. DATE SIGNED <u>2/20/66</u>		
EXAMINER'S NAME (Type) <u>Robert C. La Mar</u>			104 Bay St Snow Hill, Md.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>2-20-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fountain A</u>		23d. LOCATION (City, town or county) (State) <u>Snow Hill, Md.</u>		
24. FUNERAL DIRECTOR <u>Lorella B. Jolley</u> ADDRESS <u>Jersey Rd. Salisbury</u>					25a. REC'D BY REGISTRAR <u>FFB 25 1966</u> DATE		25b. REGISTRAR'S SIGNATURE <u>J Charles Judge</u>		

10/10/60

10/10/60



10/10/60

Driving

at 10:15 AM

[Signature]

Report of 10:15 AM 10/10/60

10/10/60